Exhibit 4

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

IN RE NATIONAL PRESCRIPTION OPIATE LITIGATION	MDL No. 2804
	Case No. 17-MD-2804
APPLIES TO ALL CASES	Hon. Dan A. Polster

- - -

Tuesday, April 23, 2019

- - -

HIGHLY CONFIDENTIAL - SUBJECT TO FURTHER CONFIDENTIALITY REVIEW

- - -

VIDEOTAPED DEPOSITION of MATTHEW PERRI, III, BS Pharm, Ph.D., RPh, held at Jones Day, 1420 Peachtree Street, N.E., Suite 800, Atlanta, Georgia, commencing at 9:28 a.m., on the above date, before Susan D. Wasilewski, Registered Professional Reporter, Certified Realtime Reporter and Certified Realtime Captioner.

- - -

GOLKOW LITIGATION SERVICES
877.370.3377 ph | 917.591.5672 fax
deps@golkow.com

APPEARANCES:
Counsel for Plaintiffs:
LIEFF CABRASER HEIMANN & BERNSTEIN, LLP
BY: MARK P. CHALOS, ESQUIRE
mchalos@lchb.com
222 2nd Avenue South, Suite 1640
Nashville, Tennessee 32701-2379
Phone: (615) 313-9000

CRUEGER DICKINSON LLC
BY: KRISTA K. BAISCH, ESQUIRE
kkb@cruegerdickinson.com
4532 North Oakland Avenue
Whitefish Bay, Wisconsin 53211
Phone: (414) 210-4367

Counsel for Endo Health Solutions Inc., Endo Pharmaceuticals Inc., Par Pharmaceutical, Inc., Par Pharmaceutical Companies, Inc., f/k/a Par Pharmaceutical Holdings, Inc.
ARNOLD & PORTER KAYE SCHOLER LLP
BY: SEAN HENNESSY, ESQUIRE
sean.hennessy@arnoldporter.com
601 Massachusetts Avenue, NW
Washington, D.C. 20001-3754
Phone: (202) 942-5000

Counsel for Walgreens Defendants:

BARTLIT BECK LLP
BY: LESTER C. HOUTZ, ESQUIRE
lester houtz@bartlit-beck.com
1801 Wewatta Street, Suite 1200
Denver, Colorado 80202
Phone: (303) 592-3100

APPEARANCES:
Counsel for McKesson Corporation:
COVINGTON & BURLING LLP
BY: MEGAN L. RODGERS, ESQUIRE
mrodgers@cov.com
3000 El Camino Real
5 Palo Alto Square, 10th Floor
Palo Alto, California 94306-2112
Phone: (650) 632-4700

Counsel for Purdue Pharma L.P., Purdue Pharma Inc., and The Purdue Frederick Company:

LYNN PINKER COX HURST
BY: JOHN VOLNEY, ESQUIRE
jvolney@lynnllp.com
2100 Ross Avenue, Suite 2700
Dallas, Texas 75201
Phone: (214) 981-3800

Counsel for Walmart Inc., f/k/a Wal-Mart Stores, Inc.:

JONES DAY
BY: EDWARD M. CARTER, ESQUIRE
emcarter@jonesday.com
325 John H. McConnell Boulevard, Suite 600
Columbus, Ohio 43215
Phone: (614) 649-3939

Counsel for Allergan Finance, LLC:
KIRKLAND & ELLIS LLP
BY: ERICA B. ZOLNER, ESQUIRE
erica.zolner@kirkland.com
ZACHARY A. CIULLO, ESQUIRE
zac.ciullo@kirkland.com
300 North LaSalle Street
Chicago, Illinois 60654
Phone: (312) 862-3247

APPEARANCES:
Counsel for Teva Pharmaceuticals USA, Inc., Cephalon, Inc., Watson Laboratories, Inc., and Actavis LLC:
MORGAN LEWIS & BOCKIUS, LLP
BY: MELISSA M. COATES, ESQUIRE
melissa.coates@morganlewis.com
200 South Biscayne Boulevard, Suite 5300
Miami, Florida 33131
Phone: (305) 415-3000

Counsel for Rite Aid:

MORGAN LEWIS & BOCKIUS, LLP
BY: MATTHEW R. LADD, ESQUIRE
matthew.ladd@morganlewis.com
101 Park Avenue
New York, New York 10178-0060
Phone: (212) 309-6000

Counsel for AmerisourceBergen Corporation and AmerisourceBergen Drug Corporation:

REED SMITH LLP
BY: JOSEPH MAHADY, ESQUIRE
jmahady@reedsmith.com
1717 Arch Street, Suite 3100
Philadelphia, Pennsylvania 19103
Phone: (215) 851-8100

Counsel for Johnson & Johnson and the Janssen Pharmaceuticals Defendants:

O'MELVENY & MYERS LLP
BY: ROSS B. GALIN, ESQUIRE
rgalin@omm.com
7 Times Square
New York, New York 10036-6537
Phone: (212) 326-2000

APPEARANCES:
Counsel for Cardinal Health, Inc.:
WILLIAMS & CONNOLLY LLP
BY: JOSHUA D. TULLY, ESQUIRE
jtully@wc.com
725 Twelfth Street, N.W.
Washington, D.C. 20005
(202) 434-5000

Counsel for Mallinckrodt LLC:

ROPES & GRAY LLP
BY: ELIZABETH BIERUT, ESQUIRE
elizabeth.bierut@ropesgray.com
1211 Avenue of the Americas
New York, New York 10036-8704
Phone: (212) 596-9000

APPEARANCES VIA TELEPHONE AND STREAM:

Counsel for the Henry Schein Defendants:

LOCKE LORD LLP
BY: BRANDAN MONTMINY, ESQUIRE
brandan.montminy@lockelord.com
2200 Ross Avenue, Suite 2800
Dallas, Texas 75201
Phone: (214) 740-8445

Counsel for H.D. Smith LLC:
BARNES & THORNBURG LLP
BY: MONIQUE HANNAM, ESQUIRE
hannam@btlaw.com
11 South Meridian Street
Indianapolis, Indiana 46204
ALSO PRESENT:
JOSHUA COLEMAN, Videographer
JONATHAN JAFFE, jjaffe@its-your-internet.com

INDEX

Testimony of: MATTHEW PERRI III, BS Pharm, Ph.D., RPh

EXHIBITS

(Attached to transcript)

EXHIBITS

(Attached to transcript)

THE VIDEOGRAPHER: We are on the record. My name is Josh Coleman. I'm the videographer for Golkow Litigation Services. Today's date is April 23rd, 2019. The time is approximately 9:28 a m.

This deposition is being held in Atlanta, Georgia, in the matter of In Re: National Prescription Opiate Litigation for the United States District Court, Northern District of Ohio, Eastern Division.

The deponent is Matthew Perri. Counsel will be noted on the stenographic record.

The court reporter is Susan Wasilewski, who will now swear in the witness.

THE COURT REPORTER: Would you raise your right hand?

Sir, do you solemnly swear or affirm the testimony you're about to give will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: Yes, I do.

THE COURT REPORTER: Thank you.

MATTHEW PERRI, III, BS Pharma, Ph.D., RPh, called as a witness by the Track One Defendants, having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. VOLNEY:

Q. Dr. Perri, my name is John Volney. I represent Purdue Pharma in this case. I'm here to take your deposition as an expert for the plaintiffs in the matter. You understand that?

A. I do.

Q. Have you given a deposition before?

A. Yes, I have.

Q. How many times?

A. In matters like this, three, I believe, three times.

Q. So --

A. Possibly four.

Q. So you understand how the process works?

A. Yes, I do.

Q. So it's going to be important today that you let me finish my question before you begin your answer. Understand?

A. I do.

Q. And I'll do the same. I will try to provide you the courtesy of letting you finish your question before I ask my next question. Is that fair?

A. It's fair, and I appreciate that.

Q. And you understand that it's your obligation

Page 102

that -- that it was the opioid marketing that began in and around that time period that created that sustained increase in utilization of opioids.

Q. Let's move on to -- let's see. We've talked a little bit about Paragraph 29 and the heightened standards that you've identified in your -- the heightened standards for pharmaceutical marketing in Paragraph 29, but then in Paragraph 35, you talk about basic standards.

Do you see that?

A. Let me get there. So just a small distinction there. The heightened standards apply for prescription drugs over other consumer goods, and then these are additional standards that apply to pharmaceutical marketing above and beyond.

Q. I notice that in Footnote 35, which is the backup for the basic standards comment, you've identified a number of articles.

A. Yes.

Q. And it looks like most of those articles come from medical journals or publications from places outside of the United States; is that right?

A. I specifically wanted to -- opioids are a drug that are used worldwide. And they -- there are agencies, associations, and so forth worldwide

Page 103

that -- that have published opinions and so forth, and recommendations, guidelines, if you will. So I wanted to be sure to be as complete as possible there, but there are also those cited from the United States as well.

Q. Which are which ones?

A. That would be the PhRMA citation.

Q. Oh, the Pharmaceutical Research and Manufacturing Association's Code on Interaction With Healthcare Professionals?

A. Yes.

Q. Are there any others that come from the US?

A. So to the extent that US manufacturers are also involved in some of these other countries, for example, just in general, the World Health Organization, you know, being involved in -- at the global level, there may be some overlap there, but I'm pretty sure that's the only one that is specific to the US. I mean, yeah, that's --

Q. Is that right?

A. It is. I -- I just was -- you know, I was looking at it. It just struck me that, you know, several defendants are, you know, multinational firms, and some of these citations actually come from their home countries, so --

Page 104

Q. Was that your intent to --

A. I just wanted to be as complete as possible.

Q. So why don't we take a break, have lunch, come back at 12:30. Is that cool?

A. That's fine. Thank you.

THE VIDEOGRAPHER: We are now going off the video record. The time is currently 11:45 a m. This is the end of Media Unit Number 1 -- Number 2.

(Recess from 11:45 a.m. until 12:59?p.m.)

THE VIDEOGRAPHER: We are now back on the video record with the beginning of Media Number 3. The time is currently 12:59 p m.

BY MR. VOLNEY:

Q. Okay. Let's -- let's get back to it. I have some questions -- I want to return to Figure 2 in your report, which is Exhibit 1, so maybe you could turn to that. Frankly, I'm hoping that you can help me understand what this Figure 2 is intended to show.

So what is Figure 2 intended to show?

A. Sorry. Figure 2 is a graphic representation of the decision process that physicians use -- actually, any -- anyone would use in deciding whether or not to purchase a product or to utilize a

Page 105

product. That's the -- I'm looking over to my left to see. It's the blue -- the blue boxes.

Q. The blue boxes show what?

A. So that is sort of the -- it's the -- the short version of the information processing model. It's where the actual decision or product choice gets made. And that is the -- begins with a patient's need.

It's adapted in this case. This is a model that has been utilized in marketing for literally decades. It's adapted in this case to apply specifically to the physician prescribing decision.

But it begins with patient's need or a recognized -- problem recognition or need identification, and then that's followed by product information search, an evaluation of alternatives by the prescriber, and then choice of a prescription medication, the patient's eventual use of that medication, and then some outcome from that.

The patient either was satisfied with the result or not. In this case, they either found that it relieved their pain or it doesn't. They found that it made them nauseous or it didn't. And that information then feeds back into the repeat process for when a repeat use is necessary. So that's the

Page 106

bottom -- that's the mainstay of the decision process.

What's important about this model is it shows you how the information that's available in the marketplace relates to the -- the blue boxes where the decision is made. So if you look to the right, we have a lot of external influences, things that are innate to the prescriber, perhaps, such as culture or other issues, other -- other characteristics like that.

The -- the box below that, individual differences, includes several things that -- that are slightly different, for example, including attitudes and personality.

So these -- these factors do play into the decision model because your beliefs, values, your attitudes and perceptions have a big part -- a big part to play in your decision-making.

Just -- so, for example, if you held the belief that -- that drug companies were stellar in their -- their research and that the clinical trials that they -- they publish and so forth were just, you know, really the gold standard, then that would positively impact your decisions in this model.

If, on the other hand, you thought that

Page 107

there was always the potential for commercial bias when a drug company sponsors research, that might flavor you in a negative way. So these kinds of influences are important.

And if you swing over to the -- to the external stimuli completely opposite that on the left side of the model, we see that there are active stimuli in the marketplace that go beyond a patient showing up with a need or your own individual characteristics or the environment surrounding all of it, and that includes marketer-dominated and marketer -- and nonmarketer-dominated influences in the marketplace.

These become important when a physician doesn't have all the information that they need and they are searching for more information so they can provide the best care to their patient.

So marketer-dominated and nonmarketer-dominated stimuli that are the result of either company marketing efforts or an article that is read or interaction with colleagues, that all then begins to be processed by the physician or prescriber through the green boxes, which model the steps that you go through in incorporating information that's gleaned from the external stimuli

Page 108

into your thought processes and cognition.

So sort of the right-hand side of the model is more on the affective side, the green boxes are more on the cognitive side, and something ends up in your memory, something ends up as a knowledge that you've gained that when you have a patient that shows up with a need, back to the blue boxes now, you then reach back into your memory and pull that information out and use it.

So it is a fairly complete structuring of how different influences impact that ultra-important decision to prescribe a medication for a patient.

Q. Okay. Looking at this model, where does the physician's training factor in?

A. That could come in a couple of different places. For example, it could come from memory. They've been taught in school, so they've attended information. They've understood it or accepted or rejected it, built it into their memory banks. So it could come under memory.

It could also come in terms of their individual differences. They could have had a professor in medical school that said, hey, never believe anything a drug company tells you, and that's going to impact the way they look at things

Page 109

from then on. So it could affect their perceptions, their attitudes, their beliefs, but it would come into play through one of these avenues in the model.

Q. Okay. Now, what about a particular practitioner's clinical experience?

A. So if you look at the blue boxes again, where we have a patient outcome, that is -- in marketing we have -- we have two possible outcomes, either satisfied or not satisfied. There can be ranges of that, but ultimately you either decide to use the product again or not.

So that information, if you're a prescriber and your patient is not happy or their pain was not relieved, that means I've got to go back to the drawing board and search for the next best alternative or search for the right answer; for example, increase the dose, change the medication, try some other form of therapy, whether it be drug or nondrug therapy, surgery, whatever it might be.

If the patient is satisfied, then that also factors back into the model, if you follow the arrow back up, so that the doctor would then or the prescriber would then know that the patient was happy with that alternative, they got a good outcome, and they continue to prescribe.

Page 110

Q. What about the clinical experience that would have been gleaned by a prescriber who regularly prescribed a certain type of medication to a group of patients?
A. Well, that -- that's -- this is a -- this model is intended to represent a collection of data points, not just an individual patient, although it -- the decision process could apply to an individual patient.
So if a doctor has lots and lots of experience with a particular outcome in his patients or her patients, then that information feeds back into their memory as -- and will flavor their future prescribing decisions.
Q. So then conversely, if a doctor had a negative experience with a patient with a particular drug, the doctor might decide -- or might be more reluctant to prescribe that to a new patient or a different patient; fair?
MR. CHALOS: Object to the form.
A. So, again, the -- I can only look at this from the marketing perspective. So if we talk in terms of satisfaction and dissatisfaction, I'd agree with that. If the outcome is one that the patient had a good outcome and the doctor deemed that to be

Page 111

a positive, then it would bode well for future use.
So within the scope of an individual patient, I can't really comment on that, but within the scope of the marketing outcome, satisfaction and dissatisfaction, I agree with that.
Q. I take it what -- or one of the things I gleaned from this particular diagram is that there is a range of information that's in the mix when a person in a clinical setting, a doctor in a clinical setting, decides whether to prescribe a certain medication; fair?
A. There is a lot of information that has to be processed. That's absolutely true.
Q. And one of the subsets of information that a doctor would have to process would be marketing information?
A. Yes, that's true. They would be -- they would need to process that information because -- and I -- I'm pretty sure I -- I addressed this to some degree in the report. They've got to stay current on -- with their drug knowledge and their disease knowledge, and one of the ways they do that is the information provided by marketing.
Q. And I think you would agree with me that in your experience -- I think you've referenced it here

Page 112

today or just now -- that some doctors look down their nose at pharmacy company advertising; fair?
MR. CHALOS: Object to the form.
A. Yeah. I think that's -- that's something that if you -- if you look at the citations of -- that are included in the report, you would see that there are a number of cites, and also agreeing with that proposition that -- that doctors are skeptical about the information they see if it's advertising information.
Q. Okay. Let's -- let's continue on our waltz through the report here. Let's go to Paragraph 39.
A. Okay. I'm with you.
Q. So in terms of the decision-making process before an actual patient gets a drug or medicine, there are a number of different potential -- well, I guess earlier we talked about gatekeepers before a drug makes it from a concept to patient, and those gatekeepers include these gatekeepers that you list here, prescribers, payers, sites of care, and influencers; fair?
A. So you refer to them as gatekeepers. I think -- I think the discussion we had this morning was more -- and I'm not -- not necessarily disagreeing with you, but I think the discussion we

Page 113

had this morning was more focused on, you know, a checks and balances of a gatekeeper. These are -- these -- these customers are -- in this context are facilitators.
Q. Facilitators, what do you mean by that?
A. So in order to sell a product, the pharmaceutical marketer has to appeal to the interest and the needs of these customers to satisfy the needs that they have, and so they're -- they're really not looking at this as a gatekeeper. It's more of a how do we meet customer needs, and what -- who are those customers? And that's what I've identified in this paragraph.
Q. Okay. I think you're answering my question from the perspective of the pharmaceutical company; fair?
A. Yes.
Q. But from the perspective of the customer or the -- ultimately the patient, these will be gatekeepers before the drug makes it from the pharmacy to their medicine cabinet; fair?
A. So I think they --
MR. CHALOS: Object to the form.
A. These would be people that would have an influence over what drug ends up in the patient's

Page 114

hands. I agree with that, yes.
Q. And then some of these influences that are reflected here or influences that these people exercise would also go into -- for this physician prescribing information processing model; fair?
A. They would have an entrance to that model, yes.
Q. Okay. So they're in the mix, in other words?
A. Each of these -- each of these customers could have, in any instance, an impact on the choices available to a -- to a prescriber which would affect their decision process.
Q. Okay. Do you know, was there any direct-to-consumer marketing by the defendant manufacturers in this case?
A. Direct-to-consumer marketing, yes.
Q. Okay. What kind of direct-to-consumer marketing are you aware of?
A. So there were numerous patient brochures and patient-oriented materials that were distributed. In addition to -- my assessment, in addition to that, there was the work through advocacy groups that were supported by defendants. And those are both forms of direct-to-consumer marketing, which I

Page 115

distinguish in my report from direct-to-consumer advertising.
Q. Okay. What's the difference between direct-to-consumer marketing and direct-to-consumer advertising?
A. So marketing is the broad umbrella, and advertising would be a very specific -- it's what you and I see when we wake up in the morning to Ozempic commercials or something else where we're seeing advertisements that are aimed at product sales directly in the media aimed at consumers.
Q. Do you consider the activities of advocacy groups to be direct consumer marketing by the drug manufacturers?
A. At the end of the day, yes, I do.
Q. And why is that?
A. Their activities were part of their marketing plans and designed to advance the messages and marketing -- and using marketing strategies that the defendants sought to advance in the marketplace, so it becomes a part of their marketing.
Q. Okay. Let's see. Have you made an effort, in considering the marketing pieces that you've included in your report and in your chart, to show how -- or take into account how the marketing

Page 116

changed over time?
A. Yes, I think I have.
Q. Are you aware that marketing has changed over time?
A. I think it did -- it did -- there's two answers to that. The specific tactics remained about the same through the entire period of this case, the strategies and so forth. The messages changed over time. The products changed somewhat over time.
Q. You mentioned before our lunch break that part of the reason you feel comfortable making the assumption that defendants' marketing messages at large were misleading is because of the existence of the FDA warning letters. Is that fair?
A. Yes.
Q. Do you know whether any defendant took corrective action as a result of any warning letter?
A. Yes, I think they did.
Q. Are -- do you know whether that corrective action was successful?
A. I guess it depends on how you define successful.
Q. Well, have you made any effort in your analysis to evaluate whether that corrective action

Page 117

was successful in any particular case?
A. So, I mean, if we take the package insert change for OxyContin, and you -- you look at, you know, what -- what -- the circumstances surrounding that change, the circumstances on -- that surround -- which are completely marketing behaviors, of getting the information that ended up in the original OxyContin package insert into that package insert and the negotiations that went on with the FDA, where the FDA got their information, and how the FDA used that information and how it ended up being the way it was, and then you look at the change that was made.
The next step is to say, okay, that's good. They made the change to the PI, but what changed in the marketing? The PI might have changed, but the marketing didn't change.
So I fail to see how that would -- would impact the analysis because what I was looking at was the actual messages being used and how those messages were being communicated and the strategies of how those messages were brought to market.
Q. Is the PI part of the mix of information that a prescriber might consider before prescribing a drug to a particular patient?

Page 118

A. If they reviewed the PI, it would become part of the mix.
Q. Is it also fair to say that marketing is only part of the mix to the extent that a particular prescriber saw the marketing, remembered the marketing, and sort of put it in his or her brain; fair?
A. That is consistent with the information processioning model and how information is processed, yes.
Q. All right. So looking at this model, that's what that is sort of intended to show? If a doctor sees the marketing, is exposed to it, pays attention to it, comprehends it, accept it -- accepts it, and retains it, puts it in his memory, if a particular patient shows up, that particular drug might come to mind as a drug that is appropriate for that patient. Fair?
MR. CHALOS: Object to the form.
A. Yes, I think that's -- that's accurate. The -- I don't want to leave the model completely open, though. The -- when it says acceptance, there is also the possibility of rejection. They can reject messages as well. So acceptance is a -- is a term, it doesn't mean that you will accept every bit

Page 119

of information that you are provided, and the model does account for that.
Q. I think that's a fair point, and I understand that. I appreciate your clarification of that point. I think that's a -- that's good to hear.
The -- this physician prescribing information processing model is not -- what you're testifying about in this case is the marketing piece, if we look at the stimuli on the left. You're -- you're here to testify about sort of the pharmaceutical marketing input into that prescribing model; is that fair?
MR. CHALOS: Object to form.
A. So my analysis focused on the marketing efforts, the branded and nonbranded marketing, and -- that were designed to influence that memory and cognition, yielding an acceptance, yes.
Q. And so the way you've done that is to identify, through the Relativity database, the various pieces of marketing materials that were produced by the defendants in the case, as well as reading some deposition testimony that was provided to you from the various representatives of the defendant companies; is that fair?

Page 120

A. And relying on the literature that provides a theoretical underpinning for why those techniques are effective or not effective.
Q. Okay. Got it. Did you see any marketing from any defendant in this matter that you considered to be fair and balanced?
MR. CHALOS: Object to the form.
A. I think the -- the pieces of marketing that had more balance to them than less balance would be pieces that were related to the package insert, for example, which is obviously an approved -- an approved document.
But when I look at the marketing plans -- and there's -- there's a reason why this is true, that when I look the marketing plans, the information in those marketing plans tends to be heavily skewed towards the side of what can we do to sell more product, not what can we do to withhold product or to keep it from selling too fast.
Q. Isn't that the point of a marketing plan, to market?
A. It -- it is the point of a marketing plan, yes.
Q. And you would agree with me that in the great United States of America, drug manufacturers

Page 121

are allowed to market their products?
MR. CHALOS: Object to the form.
A. So as I've -- as I've scoped out in my report, I think that that is true as long as they adhere to the standards that have been established and that exist that relate to the marketing of pharmaceuticals.
Q. So the -- the marketing plans themselves are not documents that are intended to be shared with the prescribers, TPPs, et cetera, fair?
MR. CHALOS: Object to the form.
A. So marketing -- marketing plans are intended for, you know, the internal use of the company, but they -- the value that they bring to the table is that the marketing plans integrate the entire scope of marketing, which is why I always get a little bit nervous when we pick out one thing, like the PI, and try to talk about it.
Marketing is a integrative process, and that's another figure in my report, but the idea we can look at any one piece of information and know what's going on with marketing is just not valid. It's the entire scope of activities that are combined to create the product image, the perception in a customer's mind, the -- whether or not doctors